APPLICATION FOR ON-SITE MEDICAL WASTE TREATMENT PERMIT

COUNTY OF SAN DIEGO
DEPARTMENT OF ENVIRONMENTAL HEALTH
HAZARDOUS MATERIALS DIVISION
P. O. BOX 129261
SAN DIEGO, CA 92112-9261
(619) 338-2222

Instructions

If you generate 200 pounds or more of medical waste in any calendar month, and treat the waste, then you must complete this application and obtain a permit prior to conducting treatment.

Enclosed are the instructions and application forms for a Medical Waste Treatment Permit as required by the Medical Waste Management Act of 1990 (MWMA) for the storage and onsite treatment of medical waste in California (Health and Safety Code, Section 117600 et.al.).

State law specifies that an application for a treatment facility must be submitted and approved to operate a medical waste treatment unit. Failure to obtain a medical waste treatment permit is a violation and subject to a penalty of up to $25,000 per day and/or jail.

The application requires both general and site-specific information. If you have any questions regarding the information required, you may contact the County of San Diego, Hazardous Materials Division (HMD).

Included in this package is a copy of the applicable regulations, Chapter 21, Sections 65600 through 65628 (non-consecutive) of Title 22, California Code of Regulations, relating to minimum Standards For Permitting Medical Waste Facilities.

Upon completion of the permit application, please attach any supporting data or additional information which may substantiate your answers. Submit the permit application to:

COUNTY OF SAN DIEGO
DEPARTMENT OF ENVIRONMENTAL HEALTH
HAZARDOUS MATERIALS DIVISION
ATTN: MEDICAL WASTE COORDINATOR
P. O. BOX 129261
SAN DIEGO, CA 92112-9261
(619) 338-2222

This application will be reviewed and processed by staff from the Hazardous Materials Division. A permit processing fee will be charged to the applicant and is payable to the COUNTY OF SAN DIEGO. The fee will be calculated on a hourly basis and will depend on the amount of time it takes to review and process the application. The review fee is $80.00 per hour.

An initial application review fee of $160.00 must be submitted with this application at the time of submittal. Additional hours accrued while processing the permit will be charged to the applicant and payable when the final permit is issued.

FILE #H

OFFICIAL USE ONLY

MEDICAL WASTE TREATMENT PERMIT APPLICATION

NAME OF FACILITY:

APPLICANT NAME:

(Must be an individual=s/individuals= name(s) in addition to the corporation name.)

APPLICANT ADDRESS:

TELEPHONE NUMBER: (____)

DATE APPLICATION RECEIVED BY DEPARTMENT:
(Department use only)

I. GENERAL

A. Type of Permit Requested

Place an "X" on the appropriate line below to indicate the type of permit being applied for:

1. Type of Treatment

___ a. Steam Sterilization

___ b. Incineration

___ c. Other State DHS approved method (please specify):

B. Facility Status

Place an "X" on the appropriate line to indicate whether this application is for a new or existing facility.

1. New Facility

2. Existing Facility

If an existing facility, please indicate the purpose of this application. Place an "X" on the appropriate line below to indicate whether this is a renewal application, a facility modification, transfer of ownership, revised application, or a initial request for permit.

___ a. Initial Request for Permit

___ b. Modification

___ c. Transfer of Ownership

___ d. Permit Revision

___ e. Permit Renewal

C. Application Information **(Note: Provide the information requested below on a separate page attached to the completed application.)**

1. Estimated Weight and Volume

A summary of the weight or volume of medical waste handled or expected to be handled during the permit period. For renewals, the amount handled during the previous permit period.

2. Special Occurrences

A listing of any special occurrences such as fires, injury, property damage, accident or other unusual occurrences, or incidents involving medical waste which have occurred at the facility during the previous three years.

3. Compliance History

A description of your compliance history relative to local, state, or federal regulation regarding the handling, storage, or treatment of medical waste during the previous three years. Include information from other facilities under your control for the same period.

II. FACILITY INFORMATION

A. Facility Name

B. Facility Contact Person(s)

1. Name (last, first, middle initial) and Job Title:

2. Telephone Number (area code and number):

( )

C. Facility Mailing Address

1. Street, Route Number, or P.O. Box Number

2. City or Town, State, and Zip Code:

D. Facility Location (if different from above)

1. Street, Route Number or other specific site location, or address:

2. City or Town, State and Zip Code:

3. Telephone Number (area code and number):

( )

E. Ownership status
(Federal, state, local government, or other public or private entity.)

III. OPERATOR INFORMATION

A. Name

B. Owner or Operator

Is the name listed in III. (A.) above also the owner?

1. _____ Yes

2. _____ No

If no, please complete the following additional information.

a. Telephone Number (area code and number):

( )

b. Street or P.O. Box Number:

c. City or Town, State, and Zip Code:

IV. FACILITY OWNER

A. If the facility owner is also the facility operator as listed in III. above, disregard the B. portion of this section.

B. If the facility owner is not the facility operator as listed in III. above, complete the following items.

1. Name of legal owner of facility:

2. Telephone Number (area code and number):

( )

3. Street or P.O. Box Number:

4. City, State, and Zip Code:

V. ENVIRONMENTAL CLEARANCES

A. Pursuant to Section 65610, Chapter 21, California Code of Regulations, provide all necessary information relating to environmental clearances/permits as required.

1. A copy of the environmental impact report (EIR) or negative declaration prepared by the

lead agency or evidence that a lead agency is preparing or will prepare environmental documentation, if applicable.

2. Other information (please specify):

VI. MAP

Attach to this application a map extending for one mile beyond the property boundary identifying access roads and the type of development surrounding the facility (e.g. residential, commercial, recreational, schools, etc.)

VII. PRIMARY ACTIVITIES OF THE FACILITY

Provide a description of the nature and activities of the business which requires a permit.

VIII. FACILITY INFORMATION

A. Provide the following facility information.

1. Average monthly quantity of medical waste to be stored and/or treated on property.

2. The rated capacity per operational cycle, the time per cycle, the number of operating hours per day, and days per week of operation.

3. Type and description of medical waste being treated. What measures are employed to prevent unauthorized waste (i.e. chemical waste, chemotherapy waste, etc.) from being treated at the facility?

B. Total capacity of primary waste storage area in use.

IX. FACILITY PLAN

Provide a site map of the facility with a description of the ingress, egress, medical waste storage area(s), treatment facility location, security measures, and other areas which will be used as a part of the ongoing operation.

X. OPERATION PLAN

Append a copy of the facility Medical Waste Operation Plan and Procedures with this application.

XI. EMERGENCY ACTION PLAN

Append a copy of your Emergency Action Plan with this application.

XII. TRAINING PLAN

Append a copy of your employee Training Plan for medical waste management with this application.

XIII. CLOSURE PLAN

Append a copy of your Closure Plan and a written estimate of the cost of closing the medical waste storage and treatment areas.

XIV. MONITORING SCHEDULE

Append a copy of the Monitoring Schedule, the schedule for installation of monitoring equipment and a copy of the Operating Procedures for maintenance and testing of the monitoring equipment.

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Medical Waste Treatment Equipment Specifications:

Each medical waste treatment unit must be described below. The following information shall be completed and submitted along with the application. Submit a separate sheet for each medical waste treatment unit.

Must complete the following information: (please print or type information)

1. Date of equipment installation:

2. Manufacturer=s Name:

3. Model Number:

4. Serial Number:

5. Describe the method of treatment for the equipment (e.g. autoclaving; chemical disinfection; thermal treatment; microwaves; etc.):

6. Give the exact location and/or room number where the treatment unit will be operated:

7. What is the rated capacity of the treatment unit? _____ pounds/hour of waste treated.

8. Give the date when the treatment equipment was last serviced by a Amanufacturer-authorized@ technician:

   Date:

9. The permittee must photocopy and submit to the HMD the manufacture=s operating instructions and recommended maintenance schedule for the waste treatment equipment. Also, submit a photocopy of the manufacturer=s diagrams or schematics of the equipment.

SIGNATURE CERTIFICATION

Owner and operator certification:

I certify under penalty of perjury that this document and all the attachments have been prepared under my direction and supervision in accordance with a system to assure that qualified personnel properly gather and evaluate the information submitted. Based on my inquiry of the person or persons who manage the system, or those directly responsible for gathering the information, the information is to the best of my knowledge and belief, true, accurate, and complete. I am aware that there are significant penalties for submitting false information, including the possibility of fine and imprisonment.

Owner Name (print or type):

City: _____ State:

Date:

Signature:

Operator certification (if different from above):

I certify under penalty of perjury that this document and all the attachments have been prepared under my direction and supervision in accordance with a system to assure that qualified personnel properly gather and evaluate the information submitted. Based on my inquiry of the person or persons who manage the system, or those directly responsible for gathering the information, the information is to the best of my knowledge and belief, true, accurate, and complete. I am aware that there are significant penalties for submitting false information, including the possibility of fine and imprisonment.

Operator Name and Official Title (print or type):

City:_____ State:

Date:

Signature: